PRINTED: 04/04/2011 FORM APPROVED OMB NO. 0938-0391

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OW	IB NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A DUILDING			LETED
155767		155767	A. BUILDING B. WING			03/15/2011	
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIE	R			MERIDIAN ROAD		
SPRINGHURST HEALTH CAMPUS					NFIELD, IN46140		
			_,		1		-
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION		TAG		DEFICIENCY)		DATE
K0000	A Life Safety Code Recertification and		K00	000	This plan of correction shall s	erve	
	State Licensure Survey was conducted by				as the credible allegation of		
		e Department of Health in			compliance with all state and		
		42 CFR 483.70(a).			federal requirements governing	ng	
	accordance with	142 CFR 463.70(a).			the management of this facility. We respectfully reques	<b>.</b> +	
		2/15/11			paper compliance for this Pla		
	Survey Date: 03/15/11  Facility Number: 005954 Provider Number: 155767 AIM Number: NA  Surveyor: Phillip Komsiski, Life Safety				Correction.		
	Code Specialist						
	At this Life Safety Code survey,						
		olth Campus was found					
	1 ^ ~	ce with Requirements for					
	1 ^	•					
	1 *	Medicare, 42 CFR					
	1 *	a), Life Safety from Fire					
	and the 2000 edi	ition of the National Fire					
	Protection Associ	ciation (NFPA) 101, Life					
	Safety Code, (L	SC), Chapter 18, New					
		cupancies and 410 IAC					
	16.2.						
	- 0.2.						
	This one story fa	acility was determined to					
	1	11) construction and was					
	1	d. The facility has a fire					
	1 * *						
	1	ith smoke detection in the					
	1 -	s open to the corridors and					
	1	oing rooms. The facility					
	has a capacity of	f 60 and had a census of					
46 at the time of this survey.							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZCQJ21

Facility ID:

005954

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155767		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED 03/15/2011			
NAME OF PROVIDER OR SUPPLIER  SPRINGHURST HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE  628 N MERIDIAN ROAD  GREENFIELD, IN46140					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	Safety Code Specia 03/21/11.  The facility was with the aforeme	Robert Booher, REHS, Life list-Medical Surveyor on  found not in compliance entioned regulatory evidenced by the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		155767	A. BUILDING  B. WING			03/15/2011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
SPRINGHURST HEALTH CAMPUS			628 N MERIDIAN ROAD GREENFIELD, IN46140				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	K00	TAG	What corrective actions will be		04/11/2011
K0051		,		51		accomplished for those residents	
SS=E	-	ensure 1 of 4 smoke			found to have been affected b		
		hall, 1 of 4 smoke			the deficient practice: The sm	noke	
		nain dining room and 1			detectors have been moved the		
		tors in the laundry room			appropriate distance away fro		
		a location which would			the air handling systems in all the identified areas.How other residents having the potential to		
		detectors to function to					
	its fullest capabil	ity. NFPA 72, 2-3.5.1			be affected by the same defici		
	requires in space	s served by air handling			practice will be identified and		
	systems, detector	s shall not be located			what corrective actions will be	:	
	where air flow in	hibits the operation of			taken: An audit of all smoke detectors was conducted to		
	the detectors. Th	is deficient practice			ensure their location is the pro	per	
	could affect 19 re	esidents on 300 hall, 5			distance from the air handling		
	residents observe	ed in the main dining			systems. No further smoke		
	room and 10 resi	dents from 100 hall			detectors were identified for	l ho	
	which is adjacent	to the laundry room,			relocation.What measures will put into place or what systemi		
	including visitors	-			changes will be made to ensu		
					that the deficient practice does		
	Findings include				not recur: The aforementione	d	
	i mamgs merade	•			smoke detectors have been		
	Rasad on observe	ations on 03/15/11 during			moved the appropriate distant away from the air handling	ce	
		2:18 p.m. and 2:59 p.m.			systems. How the corrective		
		ance Supervisor, there			actions will be monitored to		
		•			ensure the deficient practice v		
		etector installed within			not recur: An audit of all smol	ke	
		supply duct on 300 hall			detectors was conducted to ensure their location is the pro	nner	
		s station, two smoke			distance from the air handling	-	
		eighteen inches of air			systems. No further smoke		
		ne main dining room and			detectors were identified for		
		tor in the clean linen side			relocation. The Director of Pla	ant	
	_	om was within two feet			Operations has overall responsibility to maintain		
		luct. Based on interview			compliance.		
	on 03/15/11 conc				Compilarios.		
	observations, it w	vas acknowledged by the					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	I	(X3) DATE SURVEY COMPLETED	
			A. BUILDING B. WING		l l	03/15/2011	
NAME OF E	DOWNED OF SUDDITED			EET ADDRESS, CITY, STATE, ZIP COD	E		
NAME OF PROVIDER OR SUPPLIER				N MERIDIAN ROAD			
	HURST HEALTH CA			EENFIELD, IN46140			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	TION LD BE	(X5) COMPLETION	
TAG			TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE	
	Maintenance Sur	pervisor the					
	aforementioned s	smoke detectors were all					
		wo feet of air supply					
		ng. It was further					
		y the Maintenance					
		lacement of the detectors with the smoke detectors					
		smoke to its fullest					
	capability.						
	3.1-19(b)						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155767	A. BUILDING B. WING			03/15/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				MERIDIAN ROAD		
SPRINGHURST HEALTH CAMPUS				I	NFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DEFICIENCY)		DATE
K0062	Based on observation and interview, the		K00	062	What corrective actions will be		03/30/2011
SS=E	facility failed to ensure 2 of 4 sprinkler				accomplished for those reside		
00 _	heads in the special dining room were free				found to have been affected by the deficient practice: Both	<sup>y</sup>	
	•	101 Section 9.7.5 refers			identified sprinkler heads in the	_	
	-	ndard for the Inspection,			restorative dining room have	<b> </b>	
		ntenance of Water-Based			been replaced by our Koorsen		
	· · · · · · · · · · · · · · · · · · ·				vendor and are now free of pa		
		ystems. NFPA 25,			debris.How other residents		
	-	sprinklers to be free of			having the potential to be affect		
		n materials, paint, and			by the same deficient practice		
	physical damage	and shall be installed in			be identified and what correcting actions will be taken: All spring		
	the proper orienta	ation (upright, pendent,			heads were audited by the	NICI	
	or sidewall). An	y sprinkler shall be			Director of Plant Operations to	,	
	replaced that is p	ainted, corroded,			ensure they are free of corrosi		
		, or in the improper			foreign materials, paint and		
	-	deficient practice could			physical damage. What		
		observed in the room on			measures will be put into place		
					what systemic changes will be made to ensure the deficient		
	main naii inciudi	ng visitors and staff.			practice does not recur: Direc	tor	
					of Plant Operations will audit		
	Findings include	•			sprinkler heads at the conclusi	ion	
					of any painting/repairs that ma		
l l		ation on 03/15/11 during			affect sprinkler heads to ensur	е	
	the tour between	12:34 p.m. and 2:15 p.m.			they remain free of corrosion,		
		ance Supervisor, two			foreign materials, paint and		
		n special dining on the			physical damage. How the		
	-	ceiling had paint on the			corrective actions will be monitored to ensure the deficie	ant	
		ed on interview on			practice will not recur: Directo		
					Plant Operations will audit		
		rent with the observation			sprinkler heads on the quarter	ly	
		ance Supervisor, it was			preventive maintenance progra	am	
	-	e two sprinkler heads had			to ensure all sprinkler heads		
	paint on the fusib	ole link which could			remain free of corrosion, foreig	gn	
	prevent the sprin	kler heads from			materials, paint and physical damage in addition to auditing		
	functioning as de				sprinkler heads at the conclusi		
	Č				of any painting/repairs. This d		
					, , , , , , , , , , , , , , , , , , ,		

005954

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  SPRINGHURST HEALTH CAMPUS  STREET ADDRESS, CITY, STATE, ZIP CODE  628 N MERIDIAN ROAD  GREENFIELD, IN46140	
SPRINGHURST HEALTH CAMPUS GREENFIELD, IN46140	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	(X5) COMPLETION DATE
TAG REQUILATORY OR LSC IDENTIFYING INFORMATION)  3.1-19(b)  Will be reported through the campus Quality Assurance Program. The Director of Plant Operations maintains overall responsibility for compliance.	DATE